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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LISA SHADE-JENNINGS, a.k.a. LISA SHADE** **201 Christopher Drive** **San Francisco, CA 94131** **Registered Nurse License No. 316826** **Public Health Nurse Certificate No. 35171** Respondent.	Case No. 2013 - 356 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 31, 1980, the Board of Registered Nursing issued Registered Nurse License Number 316826 to Lisa Shade-Jennings, also known as Lisa Shade (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on September 30, 2013, unless renewed.

3. On or about October 31, 1983, the Board of Registered Nursing issued Public Health Nurse Certificate Number 35171 to Lisa Shade-Jennings, also known as Lisa Shade (Respondent). The Public Health Nurse Certificate was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on September 30, 2013, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

7. Section 118, subdivision (b), of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

8. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

9. Section 2762 of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022."

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

10. Code section 4021 states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

11. Code section 4022 provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import . . .

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

12. Hydrocodone with Acetaminophen (brand name "Vicodin") is a schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(I), and is a dangerous drug under Code section 4022. It is indicated in the treatment of moderate to moderately severe pain.

13. Morphine Sulfate (brand name "MS Contin") is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L), and a dangerous drug under Code section 4022. It is a highly addictive narcotic that acts directly on the central nervous system to relieve pain.

14. Lorazepam (trade name "Ativan") is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug under Code section 4022. It is a psychotropic drug used for the management of anxiety disorders.

15. Oxycodone with Acetaminophen (brand names "Percocet" or "Tylox") is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1), and a dangerous drug under Code section 4022. It is used to treat moderate to severe pain.

16. Norco (generic name "Hydrocodone") is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e), and a dangerous drug under Code section 4022. It is used to treat moderate to severe pain.

17. Trazodone is the generic name of Desyril, a dangerous drug under Code section 4022. It is indicated in the treatment of depression.

COST RECOVERY

18. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

19. On or about December 13, 2010, while employed as a hospice nurse with Kaiser Hospice in San Francisco, Respondent visited Patient EG's home to give him a vitamin B-12 injection. Patient EG's daughter, KM, was also at the home. Respondent was unable to

administer the vitamin B-12 injection because she did not have any needles for the syringe. Respondent stated that she would return to the home the following day to give the injection. During this visit, Respondent was alone with Patient EG in his bedroom, where his Ativan and Vicodin were kept. Before leaving, Respondent asked KM if she could see Patient EG's medications. KM showed Respondent Patient EG's Ativan and Vicodin, and Respondent asked where the Morphine was kept. KM retrieved Patient EG's Morphine from her mother's bedroom across the hall. Respondent checked the medicines and left.

20. Respondent returned to Patient EG's home on the afternoon of December 14, 2010, to administer Patient EG's vitamin B-12 injection. During Respondent's visit, Patient EG's wife, JG, observed Respondent exiting her bedroom and closing the door behind her. JG was upset because she always kept her bedroom door closed and she had not given Respondent permission to enter her bedroom. Patient EG's Morphine was kept in JG's room, and Respondent had seen KM retrieve the Morphine from JG's bedroom the previous day. Later that evening, JG noticed that Patient EG's amber colored prescription bottle of Ativan looked empty. JG opened the bottle and was shocked to find only six Ativan pills remaining. She also checked Patient EG's Vicodin and Morphine bottles and found several tablets missing from each bottle.

21. On December 15, 2010, JG called her daughter, KM, and told her that she suspected that Respondent had taken Patient EG's missing medications. KM told her mother that she would come over the next day to count the medications. JG also mentioned the missing medications to a Kaiser social worker who visited Patient EG that day. The social worker called Respondent at that time and left her a voicemail, alerting her to the missing medications. Respondent called JG later that day and told her that she had ordered more medications for Patient EG, and also that she was ordering a Fentanyl patch for Patient EG because he was having so much pain.

22. When KM arrived at her parents' home on December 16, 2010, she and JG counted each of Patient EG's medications. Using a calendar to calculate the quantity of missing medications, JG and KM determined that the following medications were missing: approximately 30-40 tablets of Vicodin, 50 tablets of Ativan, and 40 tablets of Morphine. Patient EG's last

order for Vicodin was on June 15, 2010, his last order for Morphine was on November 16, 2010, and his last order for Ativan/Lorazepam was on November 25, 2010.

23. Clinical notes prior to and after December 15, 2010, indicate that Patient EG's pain level was between 0-3. Clinical notes also indicate that Patient EG took one 15 milligram tablet of Morphine each night for sleep and no other medication during the day. Respondent called the pharmacist and ordered 100 tablets of Morphine for Patient EG on December 15, 2010, however according to Respondent's clinical notes, Patient EG would only have taken 29 tablets since his last refill of Morphine on November 16, 2010. Clinical notes also indicate that Patient EG was not taking Vicodin.

24. After Kaiser Hospice received the report of the missing medication from Patient EG's home, Kaiser conducted a pain and medication audit for Respondent's patients during the month of December 2010. The records for five of Respondent's ten patients, including Patient EG, indicated issues with Respondent's medication management, including re-ordering narcotics either very early or re-ordering narcotics for patients who were not using the medication or had no need for a refill. The circumstances are as follows:

PATIENT FN

25. On or about September 10, 2010, Patient FN was prescribed 100 tablets of Vicodin 5/500, and was to take one-half tablet to one whole tablet every 6 hours for pain. On or about November 10, 2010, Respondent re-ordered 100 tablets of Vicodin 5/500 for Patient FN. On or about December 15, 2010, Respondent again re-ordered 100 tablets of Vicodin 5/500 for Patient FN. Patient FN took only two tablets of this medication on October 21, 2010, and on November 8, 2010. Patient FN was not taking Vicodin for pain and there is nothing in Patient FN's chart to support Respondent's re-ordering of the medication on November 10, 2010, or December 15, 2010.

26. On or about November 10, 2010, Respondent ordered 100 tablets of Lorazepam for Patient FN. On or about November 29, 2010, Respondent re-ordered 100 tablets of Lorazepam for Patient FN. Respondent did not chart the administration of this drug for thirteen visits between November 15, 2010, and December 21, 2010.

PATIENT MM

27. On or about November 17, 2010, Respondent ordered 30 tablets of Lorazepam 0.5 milligrams for Patient MM. On or about December 15, 2010, Respondent ordered 50 tablets of Lorazepam 0.5 milligrams for Patient MM. Patient MM did not use this medication.

PATIENT MR

28. Patient MR began hospice care on or about November 8, 2010. On or about November 10, 2010, Respondent ordered 100 tablets of Trazodone 50 milligrams for Patient MR. Respondent wrote in the notes that it was a re-fill, however clinical notes indicate that Patient MR did not take this medication, and pharmacy records indicate that it was a one-time order for Patient MR. Clinical notes indicate that Patient MR did not take this medication.

PATIENT EW

29. Patient EW began hospice care on or about October 2, 2010. On or about October 11, 2010, Respondent documented that in a 24-hour period, the patient took 4 tablets of Hydrocodone 5/500 milligrams. On or about October 12, 2010, Respondent re-ordered 60 tablets of Hydrocodone 5/500 milligrams for Patient EW. On or about October 22, 2010, Respondent re-ordered 100 tablets of Hydrocodone 5/500 milligrams for Patient EW. Respondent did not document this re-order in the clinical notes. On or about November 15, 2010, Respondent re-ordered 100 tablets of Hydrocodone 5/500 milligrams for Patient EW. On or about November 29, 2010, Respondent re-ordered another 100 tablets of Hydrocodone 5/500 milligrams for EW.

30. On or about November 23, 2010, Respondent ordered 100 tablets of Norco 10/325 milligrams for Patient EW. On or about November 24, 2010, Respondent re-ordered 50 tablets of Norco 10/325 milligrams for Patient EW. Respondent did not document re-ordering the Norco for Patient EW. On or about November 29, 2010, Respondent documented that Patient EW took Norco the previous night, but that it was too strong for the patient.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct)
(Bus. & Prof. Code § 2761, subd. (a))

31. Respondent has subjected her registered nurse license to disciplinary action under Code section 2761, subdivision (a)(1), in that she was incompetent or grossly negligent in carrying out usual licensed nursing functions. The circumstances are set forth in paragraphs 19 through 30, above.

SECOND CAUSE FOR DISCIPLINE
(Possession of Controlled Substances)
(Bus. & Prof. Code § 2762, subd. (a))

32. Respondent has subjected her registered nurse license to disciplinary action under Code section 2762, subdivision (a), in that she unlawfully obtained or possessed controlled substances. The circumstances are set forth in paragraphs 19 through 30, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 316826, issued to Lisa Shade-Jennings, also known as Lisa Shade;

2. Revoking or suspending Public Health Nurse Certificate Number 35171, issued to Lisa Shade-Jennings, also known as Lisa Shade;

3. Ordering Lisa Shade-Jennings, also known as Lisa Shade, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: NOVEMBER 2, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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